## RELATIVE DISCLOSURE AND SAFEGUARDS ACKNOWLEDGEMENT FORM

## RELATIVE PROVIDER DISCLOSURE REQUIREMENT

Due to changes in the waivers July 1, 2011 because of House Enrolled Act 91, each relative or legal guardian who provides services to a related waiver participant or intends to provide services are required to disclose the relationship and acknowledge and address the safeguards set forth by the Behavioral Health Division — Developmental Disabilities (BHD DD). This form is required for every provider or employee of a provider who is providing services to a related waiver participant.

Participants have until December 31, 2011 to transition to a new provider if both the case manager and another provider on the plan are related to the participant (i.e. Joe's sister is his case manager and his aunt is his respite provider.) If a guardian of a participant age 18+ is providing direct services or is an officer or owner of a provider agency serving their ward, they must disclose the relationship and can no longer receive reimbursement for serving their ward. More information on this requirement can be found in the Division Memorandum dated July 15, 2011.

## **FORM INSTRUCTIONS**

This form shall be filled out by each relative providing services to a waiver participant, either as a certified Waiver Provider, an employee of a Provider, or a self-directed employee.

**One Form is needed per relative, per participant!** The form is to be reviewed, completed and signed by the provider, the participant's case manager, and the participant and guardian, if applicable.

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Section 1. RELATIVE DISCLOSURE INFORMATION							
Participant Name:	Participant Birthdate:	Plan Start Date:	Waiver:				
Relative Name:	Provider Agency Name:	Case Manager Full Name & Organization Name:					
1. Are you providing services to a participant who is related to you? If yes, mark how you are related:  parent/stepparent* legally appointed guardian*** sibling aunt uncle  grandparent step-family child age 18+ of a waiver participant 1st cousin Other:  * Parents/Stepparents and Guardians of minors who provide services as a certified provider shall also be a Limited Liability  Company (LLC) or a corporation as specified by House Enrolled Act 91.							
**Legally Appointed Guardians of adult participants ages 18+ may not receive reimbursement for providing services.							
2. Do you live in the same residence/same address as the participant? YES NO							
3. Are you employed to provide services through Self-direction by the related participant? YES NO							
4. Are you employed by a Waiver Provider to provide services to the related participant?   YES   NO							
5. Mark each service you will provide as a relative (see superscript notes for limitations):  Case Management¹ Support Brokerage¹ Respite² Personal Care³ Child Habilitation²  Companion² Residential Habilitation Day Habilitation Supported Living Residential Habilitation Training²  Specialized Equipment² Community Integrated Employment² Environmental Modifications  NOTE: ¹Denotes that parents/guardians/EORs may provide the service but are excluded from payment for providing that service   ² Denotes that parents/stepparents are excluded from providing the service to their child  ³ Denotes that the service may be provided to a participant under age 18 by a legally responsible individual							
(i.e. Parent/stepparent/legally appointed guardian)							
6. Is the participant receiving services from a related case manager and another service from a relative?  YES NO If "no", then no transition is needed. If "Yes", then answer question 8.							
7. If you are a related case manager, are you providing other services to the participant on the plan?  YES NO If "no", then no transition is needed. If "Yes", then answer question 8.							
8. If question 6 or 7 is "Yes", the participant must address the conflict of interest and transition out of services from one of the related providers. Date transition will take place://_ Which service is going to change? Brief Summary of Transition Plan:							

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	Sec	tion 2. P	ROVIDER SAFEGI	JARD A	<b>ACKNOWLEDGMEN</b>	T	
		The Case M	lanager and the relati	ve provid	ler shall acknowledge		
		each safeg	guard listed below and	initial in	the space provided.		
CM P	developed and m which means the	nonitored by a case manage	case manager without a c r shall not be employed by	onflict of i	est interest of the participant, interest to the relative provider it to the relative provider or the sin, step family, or the participation.	r or the participant, e participant (i.e. Sibling,	
N/A CM P	<b>Self-Directed "Relative" Employees.</b> For participants self-directing and hiring relatives, the employer must provide supervision and oversight of employees and ensure that claims are submitted only for services rendered. The Financial Management Service subagent (Agency with Choice or PPL) shall ensure that claims are submitted only for services authorized in the self-directed budget allocated by case managers.						
CM							
P	services otherwise available to the participant (i.e. assistance normally provided by family, school, Medicaid State plan, etc.						
N/A CM P	I narticinant shall not exceed tour (/I) hours her narticinant her day when the related provider lives in the same residence						
CM P	Relative Emplo parents, to provi qualified to provi	yees Hired b de waiver serv de the service	y a Provider or Agency vices in accordance with W	with Choi yoming M provide su	<b>ce.</b> Provider agencies may hire edicaid Rules Chapter 45, as lopervision and oversight of emp	ong as the relative is	
CM P	I same requirements and qualifications as other providers or employees and are subject to the same oversight levels as						
CM P	interest of the pa work to resolve t	nrticipant, the o	case manager, participant,	appropria	ated provider is not providing te team members, and the Di ate. The plan of care shall be	vision as needed, shall	
CM	Service Observa	ation. All serv	ices shall be observed qua	rterly by th	ne case manager and reviewed	for appropriateness	
P					rve services as needed through		
CM P	Rules Chapter 45 shall be for service	, which suppo ces specific to t e documentat	rt the services claimed for the plan and to the service ion shall be reviewed mon	reimburse definition	te delivery in accordance with ement. Service documentation, not the support naturally expected manager to verify that services.	of the related provider pected and provided by	
CM P	Prior Authoriza	tion. The amo	ount of waiver services sha	•	authorized by the Division and ed as specified in the individua	-	
CM P	_	n the provider	-	-	and are subject to post-paym n concerns found to not meet		
case ma	nager and provid	der agency sh	all maintain a copy of th	e approv	n shall review, complete and ed form signed by the Divisor to the designated Provider	ion in their master	
Particip	ant Signature	Date	Guardian Signature	Date	Related Provider Signatu	re Date	
Case M	anager Signature	e, Organizatio	on Name, & Date	DIVISIO	DN SIGNATURE	APPROVAL DATE	

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